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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DOROTHY DENEE MILLETT** **182 E. Rocky Pt Lane** **Belfair, WA 98528** **Registered Nurse License No. 633633** Respondent.	Case No. 2010-318 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 2, 2004, the Board issued Registered Nurse License Number 633633 to Dorothy Denee Millett ("Respondent"). Respondent's registered nurse license expired on June 30, 2009.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
>
> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Code section 4060 states, in pertinent part:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant

> to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 . . .

8. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself.

9. Health and Safety Code section 11173, subdivision (a), states, in pertinent part, that "[n]o person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . ."

10. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

11. Regulation 1443 states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

12. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

13. "Dilaudid" , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

14. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

15. "Vicodin" is a compound consisting of 5 mg hydrocodone bitartrate, also known as dihydrocodeinone, and 500 mg acetaminophen per tablet, and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

16. "Ativan", a brand of lorazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16).

17. "Benzodiazepine" is a generic classification for drugs consisting of Schedule IV controlled substances.

18. "Opiates" are Schedule II controlled substances as designated by Health and Safety Code section 11055, subdivisions (b)(1) and (c).

FIRST CAUSE FOR DISCIPLINE

(Diversion, Possession, and Self-Administration of Controlled Substances)

19. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that in or about August 2005, while on duty as a registered nurse in the Emergency Department at Torrance Memorial Medical Center, Torrance, California, Respondent did the following:

Diversion of Controlled Substances:

a. Respondent obtained the controlled substances Dilaudid, morphine, Vicodin, and Ativan by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: In or about August 2005, Respondent removed various quantities of Dilaudid, morphine, Vicodin, and Ativan from the Omnicell automated dispensing system ("Omnicell") for certain patients (patients 1 through 9) when there were no physicians' orders authorizing the medications for the patients, or the quantities of the medications removed from the Omnicell were in excess of the doses ordered by the patients' physicians. Further, Respondent failed to chart the administration of the controlled substances on the patients' Medication Administration Records (MAR), failed to document the wastage of the controlled substances in the Omnicell, or falsified or made grossly incorrect, grossly inconsistent,

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or unintelligible entries on the MAR's to conceal her diversion of the controlled substances, as set forth in paragraph 21 below.

Possession of Controlled Substances:

b. In or about August 2005, Respondent possessed unknown quantities of the controlled substances Dilaudid, morphine, Vicodin, and Ativan without valid prescriptions from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

Self-Administration of Controlled Substances:

c. On or about August 27, 2005, Respondent self-administered unknown quantities of benzodiazepines and opiates without lawful authority therefor, as set forth in paragraph 20 below.

SECOND CAUSE FOR DISCIPLINE

(Use of Controlled Substances to an Extent or in a Manner Dangerous or Injurious to Oneself and/or Others)

20. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (b), in that on or about August 27, 2005, while on duty as a registered nurse in the Emergency Department at Torrance Memorial Medical Center, Torrance, California, Respondent used controlled substances, including, but not limited to, opiates and benzodiazepines, to an extent or in a manner dangerous or injurious to herself and others, as follows: On the date indicated above, registered nurse K. L. observed Respondent remove 4 mg of morphine from the Omnicell for the patient in bed 11 and place the syringe in her pocket. K. L. never saw Respondent return to the patient to administer the medication. Later during her shift, K. L. received a report from another nurse that Respondent had not documented anything in three of her patients' charts, with the exception of pain medication administration (there were no patient assessments or vital signs documented). K. L. also observed that Respondent's behavior was erratic and that she had difficulty coping with her environment. K. L. reported to J. R., the Director of Emergency Preparedness, Risk Management, at the medical center, that she was concerned Respondent was taking narcotics for self-use and was providing poor documentation

on her assigned patients. Later, J. R. asked Respondent if she would consent to a drug screening test. Respondent provided a urine specimen for testing and tested positive for benzodiazepines and opiates.

THIRD CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

21. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in or about August 2005, while on duty as a registered nurse in the Emergency Department at Torrance Memorial Medical Center, Torrance, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances morphine, Dilaudid, Vicodin, and Ativan, as follows:

Patient 1:

a. On August 12, 2005, at 0804, 0904, 1005, 1120, and 1130 hours, Respondent removed five 2 mg doses of Dilaudid from the Omnicell for the patient, for a total of 10 mg of Dilaudid, when, in fact, the physician had only ordered a total of 8 mg of the medication for the patient. Further, Respondent charted on the patient's MAR that she administered four 2 mg doses of the Dilaudid, for a total of 8 mg, to the patient at 0810, 0910, 1010, and 1110 hours, but failed to account for the disposition of the remaining 2 mg Dilaudid. In addition, the patient complained to registered nurse K. L. that she did not receive any relief from the medication allegedly administered by Respondent, that she received only 0.25 cc in each injection (the ordered dose was for 1 cc), and that she did not experience the side effects she usually experienced when taking the prescribed dose of Dilaudid.

Patient 2:

b. On August 1, 2005, at 1900 hours, Respondent removed a total of 6 mg of morphine from the Omnicell for the patient and charted on the patient's MAR that she administered morphine 6 mg to the patient at 1915 hours, when, in fact, the physician's order called for the administration of "morphine 2 mg, may repeat once."

Patient 3:

c. On August 25, 2005, at 0807 hours, Respondent removed one 5/500 tablet of Vicodin from the Omnicell for the patient when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent failed to chart the administration of the Vicodin on the patient's MAR, document the wastage of the Vicodin in the Omnicell, and otherwise account for the disposition of the one Vicodin tablet.

Patient 4:

d. On August 25, 2005, at 1043 hours, Respondent removed Ativan 2 mg from the Omnicell for the patient when, in fact, the physician's order called for the administration of only 1 mg Ativan for the patient. Further, Respondent failed to chart the administration of the Ativan on the patient's MAR, document the wastage of the Ativan in the Omnicell, and otherwise account for the disposition of the Ativan 2 mg.

Patient 5:

e. On August 25, 2005, between 1726 and 1747 hours, Respondent removed a total of 10 mg of morphine from the Omnicell for patient 5 when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent wrote an order for morphine 5 mg on the Emergency Department Record, then crossed out the entry, but charted on the patient's MAR that she administered morphine 5 mg to the patient at 1730 hours (Respondent also documented in the Omnicell that she wasted 1 mg of the morphine at 1747 hours as witnessed by another nurse).

Patient 6:

f. On August 25, 2005, at 2106 hours, Respondent removed morphine 4 mg from the Omnicell for the patient and charted on the patient's MAR that she administered morphine 4 mg to the patient at 2100 hours when, in fact, there was no physician's order authorizing the medication for the patient.

Patient 7:

g. On August 26, 2005, at 0915 hours, Respondent removed morphine 4 mg from the Omnicell for the patient and charted on the patient's MAR that she administered morphine 4 mg

to the patient at 0900 hours when, in fact, there was no physician's order authorizing the medication for the patient.

Patient 8:

h. On August 27, 2005, at 1110 hours, Respondent wrote an order for morphine 4 mg on the Emergency Department Record for the patient, removed morphine 4 mg from the Omnicell for the patient at 1117 hours, then charted on the patient's MAR that she administered Morphine 4 mg to the patient at 1110 hours, when, in fact, the patient's physician had not authorized the medication for the patient.

Patient 9:

i. On August 25, 2005, at 1418 hours, Respondent removed morphine 4 mg from the Omnicell for patient 9 when, in fact, there was no physician's order authorizing the medication for the patient. Further, Respondent charted on the patient's MAR that she administered morphine 3 mg to the patient, then crossed out the entry.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in or about August 2005, while on duty as a registered nurse in the Emergency Department at Torrance Memorial Medical Center, Torrance, California, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as set forth in paragraphs 19 (a), 20, and 21 above.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

23. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that in or about August 2005, while on duty as a registered nurse in the Emergency Department at Torrance Memorial Medical Center, Torrance, California, Respondent was guilty of incompetence within the meaning of Regulation 1443, as set forth in paragraphs 19 (a), 20, and 21 above.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 633633, issued to Dorothy Denee Millett;

2. Ordering Dorothy Denee Millett to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/7/10

Louise R. Bailey

LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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